

## CFC/PAS SELF-DIRECT SERVICES DELIVERY RECORD

Employee Name		Member Name		Medicaid ID (optional)							Pay Period (Mo/Day/Yr)- Mo/Day/Yr)						
		Su	M	T	W	Th	F	S	Su	M	T	W	Th	F	S		
Employees must complete all sections of the service delivery record in order to obtain payment.	Date																
	Time In																
	Time Out																
	Total (a+b+c)																
<b>ACTIVITIES OF DAILY LIVING (ADL)</b>																	
Bathing																	
Personal Hygiene																	
Meal Preparation & Eating																	
Exercise																	
Medication Reminder																	
Other: <i>(approved by MPQH)</i>																	
<b>HEALTH MAINTENANCE ACTIVITIES (HMA)</b>																	
Medication Administration																	
Urinary System Management																	
Bowel Program																	
Wound Care																	
<b>INSTRUMENTAL ACTIVITIES OF DAILY LIVING</b>																	
Household Maintenance (HM)																	
Correspondence Assistance (CA) - CFC Only																	
<b>a) ADL, HMA, Household, Correspondence, Daily Total</b>																	
<b>b) Community Integration (CI)/Shopping -- Daily Total</b>																	
<b>c) Skill Acquisition-CFC only-- Daily Total</b>																	

A. ADL, HM and CA Total Time: \_\_\_\_ B. CI and Shopping Total Time: \_\_\_\_ C. Skill Acquisition Total Time: \_\_\_\_ Total A+B+C \_\_\_\_

All services under HCBS/Medicaid Waiver must be <u>pre-approved</u> by the case management team.	Date														
	Time In														
	Time Out														
	Total														
Social Supervision															
Homemaking															

Comments:

<p>This is to certify that I worked the hours recorded and completed the work tasks assigned.</p> <p>This is to certify that the employee has worked the hours recorded, completed the tasks assigned. <b>Misrepresentation constitutes fraud.</b></p>	<b>Member/PR Signature</b>		<b>Date</b>
	<b>PCA Signature</b>		<b>Date</b>
	<b>Provider Representative Signature</b>		<b>Date</b>